

**MARICOPA INTEGRATED HEALTH SYSTEM HEALTH PLANS
PROTOCOL**

SUBJECT: Laser Vaporization of Cervix APPLIES TO: MHP <input checked="" type="checkbox"/> MLTCP <input checked="" type="checkbox"/> MSSP <input checked="" type="checkbox"/> HEALTHSELECT <input checked="" type="checkbox"/>	Protocol #: PA P187.00 Protocol Pages: 1 Attachments: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Initial Effective Date: June 1999 Latest Review Date: May 2002
MIHS HEALTH PLANS APPROVALS: Director, Medical Management: _____ Date: _____ Medical Director: _____ Date: _____	

PURPOSE: The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to Laser Vaporization of Cervix.

PROTOCOL:

- A. Laser Vaporization of Cervix
CPT: 57510
LOS: OP

- B. The prior-authorization specialist may approve if **all** of the following are present:
 - 1. Abnormal pap smear with abnormal biopsy on follow-up **or** condyloma of cervix **and**
 - 2. Unable to remove lesion by LEEP.

- C. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.

- D. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.

- E. If requirements are not met, Medical Director review is required.

MIHS Health Plans reserves the right to change the protocol for administrative or medical reasons without notification to external entities. This protocol is not intended to be utilized as a basis for a claim submission.